LOC Sexual dysfunction in women, men and neurologic people and the impact of incontinence on sexual life.

Workshop Chair: Adelia Lucio, Brazil

Start	End	Topic	Speakers
09:00	09:05	Welcome and introduction	• Adelia Lucio
09:05	09:20	Role of PFMT on female sexuality	• Adelia Lucio
09:20	09:25	Questions	All
09:25	09:45	Conservative treatments for vaginismus and vulvodynia	• Mara de Abreu Etienne
09:45	09:55	Questions	All
09:55	10:20	Emotional Implications of urinary incontinence on sexual dysfunction	• Milagros Castro
10:20	10:30	Questions	All
10:30	11:00	Break	None
11:00	11:15	Sexual life of people with neurologic problems	• Helena Pantaroto
11:15	11:20	Questions	All
11:20	11:35	Conservative treatment for erectile dysfunction	• Cristiane Carboni
11:35	11:40	Questions	All
11:40	12:00	Discussion	All

Aims of course/workshop

- Discuss if sexuality can be improved in patients who undergo PFMT;
- Present and discuss, using clinical cases, conservative treatments for vaginismus, vulvodynia and erectile dysfunction;
- Talk about emotional impact, caused by urinary incontinence, on sexuality;
- And discuss how to manage the sexual life of people affected by a neurologic desease.

Sexual dysfunction in women, men and neurologic people and the impact of incontinence on sexual life.

Welcome and introduction - Adélia Lúcio

In this workshop we'll start discussing the importance of a proper pelvic floor muscle function on sexuality and after that we'll discuss conservative treatments for sexual dysfunction in women, men and neurologic people and the impact of urinary incontinence on their Quality of Life.

Role of PFMT on female sexuality - Adélia Lúcio

Pelvic floor muscles (PFM) are known to have an important role in sexual function being responsible for the involuntary rhythmic contractions during orgasm and vaginal sensation during intercourse. It is also known that a week PFM leads to a decrease in orgasm and arousal function[1]. The literature shows that women who underwent a PFM training program presented improvement after this treatment, showing the need of an adequate PFM function for a plenty sexual life[2,3].

Based on literature review we will discuss why PFM function is essential for a successful sexual life.

1 - Lowenstein L, Gruenwald I, Gartman I, et al. Can stronger pelvic muscle floor improve sexual function? Int Urogynecol J 2010; 21:553–556.

2 - Beji NK, Yalcin O, Erkan HA. The effect of pelvic floor training on sexual function of treated patients. Int Urogynecol J 2003; 14: 234–238.

3 - Zahariou AG, Karamouti MV, Papaioannou PD. Pelvic floor muscle training improves sexual function of women with stress urinary incontinence. Int Urogynecol J 2008; 19 (3): 401-406.

Conservative treatments for vaginismus and vulvodynia - Mara Etienne

Vaginismus is an involuntary spasm of the introital muscles of the vagina. Although the DSM-IV distinguishes between vaginismus and dyspareunia, several women may present both complaints. Diagnosis classifies it into primary and secondary conditions, and patients describe symptoms from a mild discomfort to a complete closure of the vagina, which is confirmed by a simple tentative to verify that. Previous theories centered it on psychological etiologies, since negative attitudes toward sex or sexual ignorance were observed, whereas recent discussions considered it a conditioned response of the perineal muscles. A history of pain is commonly associated with vaginismus and inadequate lubrication due to incomplete arousal. Vaginal pain is also suggestive of atrophic changes, transient causes such as fungal or bacterial vaginitis, vulvar dystrophies and vulvodynia[1,2,3].

Conservative measures, such as gentle vulvar care, medication, sexual counseling, or acupuncture, have been shown to bring benefits to the patients. However, it is important to have treatments which address the genital area.

Physiotherapy, using several procedures, as exercises for the pelvic girdle, soft tissue mobilization and myofascial release, vaginal dilators, electrostimulation with different electric parameters, pelvic floor muscle training, and biofeedback training, are indicated to treat vaginismus and vulvodynia with varying degrees of success[1,2,4].

The aim of this presentation is to discuss the interface of vaginismus, dyspareunia, and vulvodynia, since the symptoms that women complain about are sometimes mixed, or one followed by the other, as it will be shown in case reports, and how physiotherapy may manage them.

1. Reissing ED, Armstrong HL, Allen C. Pelvic floor physiotherapy for lifelong vaginismus: a retrospective chart review and interview study. J Sex Marital Ther. 2013;39(4):306-20.

2. Melnik T, Hawton K, McGuire H. Interventions for vaginismus. Cochrane Database Syst Rev. 2012 Dec 12;12.

3. Lynch PJ, Moyal-Barracco M, Bogliatto F, Micheletti L, Scurry J. 2006. ISSVD classification of vulvar dermatoses: pathologic subsets and their clinical correlates. Journal of Reproductive Medicine. 2007;52(1):3-9.

4. Munday P, Buchan A, Ravenhill G, Wiggs A, Brooks F. A qualitative study of women with vulvodynia: II. Response to a multidisciplinary approach to management. J Reprod Med. 2007 Jan;52(1):19-22.

Emotional Implications of urinary incontinence on sexual dysfunction - Milagros Castro

According to the Epidemiology Committee of the Fourth International Consultation on Incontinence celebrated in Paris on 2008, around 25-45% of women and approximately 50% of men report some degree of urinary incontinence.

Incontinence can affect sexuality and confidence of a person in several ways:

1. Loss of bladder control accompanied by feelings of being less masculine or less feminine.
2. The fear of having a loss during moments of intimacy can create anxiety.
3. The concern to maintain a sexual contact with urinary devices can affect confidence. [1]

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or

expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. [2].

We will talk about some of the most common worries about sex from patients with urine incontinence:

- Loss of small amounts of urine during sex.
- Incontinence of large amounts of urine.
- Being a carrier of bladder catheterization.
- Being a carrier of urostomy.
- …and so on.

We will learn to address these fears and provide our patients tools to enhance their sexual life.

1 - Cheryle B. Gartley. Managing Incontinence. Ancora S.A. 1992; 10:118
2 - World Health Organization. Defining sexual health. Report of a technical consultation on sexual health 28–31 January 2002, Geneva. 1996;3:5

Sexual life of people with neurologic problems - Helena Pantaroto

Sexual life of neurologic patients is, frequently, overlooked by health professional and also by patients. This population present, very often, motor impairment due to the neurological lesion condition and for this reason don't play the same attention to sexual dysfunction. The causes are multifactorial[1] and symptoms may vary from each lesion site.

More attention has been paid on sexual rehabilitation during the last decade since sexuality after spinal cord injury was identified as being one of the central motivation in life[2], with the restoration of sexual function or the adequate treatment of sexual dysfunction substantially influencing the overall rehabilitation outcome.

In this Work Shop we will discuss how to manage the sexual life of people affected by a neurologic disease, especially in some common neurologic diseases, such as Parkinson Disease, Multiple Sclerosis, Strokes and Spinal Cord Injury.

1- Bronner et al, 2010

2 - Reitz A; Tobel V; Knapp PA; Schurch B. Impact of spinal cord injury on sexual health and quality of life. International Journal of Impotence Research (2004) 16, 167–174

Conservative treatment for erectile dysfunction - Cristiane Carboni

The Erectile Dysfunction (ED) is defined as the inability to achieve and maintain penile erection sufficient for satisfactory sexual intercourse[1] and affects approximately 150 million men worldwide[2].

Numerous therapeutic strategies exist to improve erectile function. While these therapies have proven to be safe and effective, they have limited use prior to sexual activity and not modify the physiological mechanism of penile erection[3]. The number of men needing treatment for erectile dysfunction is increasing and treatment options continue to expand with more attractive alternatives[4].

Different treatment options are available: psycho sexual counseling, medication, use of external vacuum devices, intravenous injection therapy, vascular surgery, and use of a penile prosthesis and functional electrical therapy[5–13].

In this context, erectile dysfunction and possible treatments come solids extensively studied, searching for low-cost alternatives, and without side effects. And in this workshop we are going to check all the non invasive treatments that physiotherapist are able to.

1) Hatzimouratidis K, Amar E, Eardley I, Giuliano F, Hatzichristou D, MontorsiF, et al. Guidelines on male sexual dysfunction: erectile dysfunction and premature ejaculation. Eur Urol. 2010;57(5):804-14.

2) Ayta IA, McKinlay JB, Krane RJ. The likely worldwide increase in erectile dysfunction between 1995 and 2025 and some possible policyconsequences. BJU Int. 1999;84(1):50-6.

3) La Vignera S, Condorelli RA, Vicari E, ET AL. Endothelial apoptosis decrease following tadalafil administration in patientes with arterial ED does not last after its discontinuation. Int J Impot Res 2011.

4) Montague DR, Angermeler HW. Future considerations: advances in the surgical management of erectile dysfunction. Int J Impot Res. 2000;12(Suppl 4):S140-S143.

5) Nachtsheim D. Treating impotence. West J Med. 1994;160:168–169.

6) Sidi AA, Becher EF, Zhang G, Lewis JH. Patient acceptance of and satisfaction with an external negative pressure device for impotence. J Urol. 1990;144:1154–1156.

7) Meinhardt W, Lycklama AAB, Nijeholt et al. The negative pressure device for erectile disorders: when does it fail? J Urol. 1993;149: 1285–1287.

8) Gupta R, Kirschen J, Barrow RC, Eid JF. Predictors of success and risk factors for attrition in the use of intracavernous injection. J Urol. 1997;157:1681–1686.

9) Lakin MM, Montague DK, Vanderbrug Mesendorp S. Intracavernous injection therapy: analysis of results and complications. J Urol. 1990;143:1138–1141.

10)Lewis RW. Diagnosis and management of corporal veno-occlusive dysfunction. Semin Urol. 1990;8:113–123.

11) Padma-Nathan H. Diagnostic and treatment strategies for erectile dysfunction: the process of care model. Int J Impot Res. 2000;12 (suppl 4):S119–S121.

12 Montague DR, Angermeler HW. Future considerations: advances in the surgical management of erectile dysfunction. Int J Impot Res. 2000;12(suppl 4):S140–S143

13)Stief CG, Weller E, Noack T et al. Functional electromyostimulation of the penile corpus cavernosum: initial results of a new therapeutic option of erectile dysfunction. Urology. 1996;35:321–325.

ICS 2014
Rio de Janeiro

Notes